Washington State Department of Social & Health Services

LOCAL OFFICE	TELEPHONE NUMBER
CASE NUMBER	DATE

WORKING CONNECTIONS CHILD CARE (WCCC)

WCCC AWARD/CHANGE LETTER

FOLD

You are eligible for child care subsidies with a copayment starting _____ and ending _____ .

Please read the important information on Page 2.

You are eligible for care for the following activity(ies): ☐ Employment ☐ Approved WorkFirst activity ☐ School ☐ Other: _____.

Your beginning monthly copayment will be $15.00 for the period of _____ to _____. Your monthly copayment will ☐ be ☐ change to $_____ for period of _____ and ending _____.

A copayment is your share of your child care cost. Your copayment is based on your household size and your monthly income as follows:

1. Family size is _____
2. Gross earned income is (before taxes) $ _____
3. Self-employment income (after allowable deductions) is $ _____
4. Unearned income equals (SSI, SSA, child support received) is $ _____
5. TOTAL INCOME (add lines 1 - 4 above) $ _____
6. Child support paid out is $ _____
7. Determine countable income (subtract line 6 from line 5) $ _____
   (Countable income is used to determine eligibility and copayment)
8. Copayment is calculated as follows:

COUNTABLE INCOME	MONTHLY COPAYMENT
At or below 82% of Federal Poverty Level (FPL)	$15
Above 82% and up to 137.5% of FPL	$50
Over 137.5 and up to 225% of FPL (Countable income - 137.5% FPL) X .44 + $50	

Your copayment is changing because (per WAC 388-290-0085);

☐ Your authorization period has expired.
☐ Your income has decreased.
☐ Your family size has changed.
☐ Other (explain): _____

WORKER'S NAME

WORKER'S TELEPHONE/FAX NUMBER

WORKING CONNECTIONS CHILD CARE
INFORMATION YOU NEED TO KNOW

Return all requested information for your provider immediately. No payments will be made for care by your in-home/relative provider prior to the date all background check results are received.

Do not leave your child(ren) in care for reasons other than those listed on the front of this form, unless you have made arrangements with your provider to pay for the care yourself. If you want to participate in an activity other than what is authorized on the front of this form, and want DSHS to pay for your child care, you must first contact your child care worker.

* If you have a child with Special Needs, DSHS may be able to pay a higher rate for care of this child. Contact the Authorizing worker for more information.

When you apply for or receive WCCC benefits you have a responsibility to:

- Supply the department with information so we can determine your eligibility and authorize child care payments correctly;
- Choose a provider who meets requirements of WAC 388-290-0125 and make your own child care arrangements;
- Pay, or make arrangements to have someone pay, your WCCC copayment directly to your child care provider. **Failure to do so may result in your child care subsidies being terminated**;
- Keep and provide when requested, accurate attendance records when you choose in-home/relative child care;
- Pay your in-home/relative provider the entire amount the department sends you for in-home/relative care;
- Get a receipt for any money you pay to your provider. You must keep the receipts for one year for DSHS to review on request;
- Notify WCCC authorizing worker, within five days, of any change in providers.
- **Report to your child care authorizing worker, within twenty-four hours, any pending charges or conviction information you learn about your in-home/relative provider.**

Report changes to the WCCC authoring worker within ten days of:

- The number of child care hours needed (more or less hours);
- Household income to include TANF grant stops or starts;
- Household size such as any family member moves in or out of your home;
- Employment, school or approved TANF activity (starting, stopping or changing);
- The address or phone number of your in-home/relative provider;
- Your home address or telephone number; or
- Your legal obligation to pay child support.

Notify your provider within ten days when we change your child care authorization.

Failure to report changes promptly may result in an overpayment or you might have to pay more than your normal share of child care costs.

FAIR HEARING RIGHTS: You have a right to a fair hearing. To request a fair hearing, contact this office or write to Office of Administrative Hearings, PO Box 42489, Olympia WA 98504-2465. You must request your fair hearing within 90 days of the date you receive this decision. At the hearing, you have the right to represent yourself, be represented by an attorney or by any other person you choose. You may be able to get free legal advice or representation by contacting an office of legal services. You may be eligible to receive continued benefits pending the outcome of a Fair Hearing.

MEDICAL FOR YOUR CHILDREN

Did you know that you could get medical and dental coverage for your children? There is no waiting list and it's as easy as **1 - 2 - 3**!

1. Are you receiving any other type of assistance through the state, such as food stamps or cash assistance?
   - **YES:** Call the financial worker in charge of your case and request medical coverage for your child(ren).
   - **NO:** Call the toll free telephone number for Children's Medical assistance at 1-800-204-6429.
2. Provide the worker with the information they need to tell if you are eligible. They may already have this or be able to take it over the telephone.
3. Receive the medical card in the mail.

Don't wait - medical coverage for you child is as close as a phone call away!